The WHO GCM/NCD Working Group on the inclusion of NCDs in other programmatic areas (Working Group 3.1, 2016 – 2017) was formed under Objective 3 of the GCM/NCD 2016-17 work plan to provide a forum to identify barriers and share innovative solutions and actions for the implementation of the Global Action Plan on NCDs.

**Action 3.1:**

Establish a Working Group in 2016 to recommend ways and means of encouraging Member States and non-State actors to promote the inclusion of the prevention and control of noncommunicable diseases within responses to HIV/AIDS and programmes for sexual and reproductive health and maternal and child health, as well as other communicable disease programmes, such as those on tuberculosis, including as part of wider efforts to strengthen and orient health systems to address the prevention and control of noncommunicable diseases through people-centred primary health care and universal health coverage.

The Working Group is co-chaired by the representatives of two Member States, one from a developed country and one from a developing country, appointed in consultation with Member States:

- H.E. Beatriz Londoño Soto, Ambassador Extraordinary and Plenipotentiary; Permanent Representative to the UNOG of Colombia
- Dr Naoko Yamamoto, Assistant Minister for Director Global Health, Ministry of Health, Labour and Welfare, Japan

1. Concept of Integration

The persistent challenge facing countries, particularly in low and middle income countries, is to develop a sustainable health infrastructure which will provide quality health care in an integrated way. The idea of integrated health services is not new. It was the basis for the focus on primary health care in the 1980s. In 1996, integration was defined by the World Health Organization (WHO) in functional terms as “a series of operations concerned in essence with bringing together of otherwise independent administrative structures, functions and mental attitudes in such a way as to combine these into a whole”. More recently, in 2013 UNAIDS defined programme integration as “joining together different kinds of services or operational programmes in order to maximize outcomes”. The current challenge is to be specific about what integrated services look like in different settings and how integration can contribute to the intended aim of what WHO also defines as “the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money”.

It is important to distinguish between integrated care and integration. Integrated care is an organizing principal for service delivery, which can occur within communities, health organizations, broader health systems and across sectors. On the other hand, integration is an approach rather than an end in itself; integration describes the methods, processes and models to achieve such delivery of care. This can be achieved, for example, through organizing referrals from one service to another, through co-location, or by offering one-stop comprehensive and integrated services.

WHO’s framework on integrated people-centred health services, recently adopted at the 69th World Health Assembly, May 2016, provides a comprehensive definition of, and approach to, integrated health services that incorporates these considerations “services that are managed and delivered so that people receive a continuum of health promotion, diseases prevention, diagnosis, treatment, diseases-management, rehabilitation, and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs and throughout the life-course.”

Integrating people-centred health services at the point of service delivery provide the 'right care' for the 'right people' at the 'right place'. This refers to an integrated health promotion, prevention and disease management approach that provides continuous care, in many cases focusing on specific strategies that satisfy specific needs (i.e. health promotion, diagnosis, or treatment) to a defined population. An integrated approach is not only cost-effective but also addresses inequities in health care service delivery, through promoting the provision of standardized activities to specific populations by well-

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1 Integration of mass campaigns against specific diseases into general health services: report of a WHO Study Group. WHO 1965
2 Smart Investments. UNAIDS, 2013
5 Definition: health services: health services include all services dealing with the promotion, maintenance and restoration of health. They include both personal and population-based health services.
In an effective integrated service delivery model, tools, approaches and human resources are shared, with multidisciplinary teams of trained health workers providing comprehensive quality services. Integration should, however, follow a contextual, structured and sustainable approach, and is not limited to pilot projects. In addition, the necessary upstream integration of services means that services are not only integrated at the point of service, but that a systematic and unified approach is used for developing guidelines, training and supporting the roles and responsibilities of health workers, patient support, procurement, health records, continuous monitoring and evaluation and measuring quality improvement. This ensures that lessons are shared, systems are harmonized, resources are appropriately distributed and efficiency and quality are recognized.

Integration is not a panacea. Integration is not a cure for inadequate resources. It is not a strategy to fall back on when vertical programmes run out of funds, nor is it achieved by adding to the responsibilities of service providers without a corresponding increase in resources. Integration does not mean that specialized disciplines, programmes, personnel and services will be abolished. It does not necessarily mean that all services will be provided by multipurpose workers nor that everything has to be integrated into one package. A local health service can, therefore, continue to have vertical programmes where and when the situation requires them to but, at the same time, it should be an integrated service with the capacity to sustain the activities of a vertical programme in the long term. The two approaches are complementary. Integration is best seen as a continuum rather than as two extremes of integrated vs not integrated. Integrated care can look different at different service levels, and in different contexts. In reality, there are many possible permutations.

In line with the above, integration of NCD programmes into existing health programmes, such as HIV, Tuberculosis, maternal and child health, sexual and reproductive health and community-based primary health care, should be a process of horizontal/downstream integration of health services, bringing comprehensive integration of promotion, prevention, diagnosis and treatment of NCDs at the point of service delivery, including patient education, health promotion, referrals, counseling, support on adherence and on behavior change, decentralizing clinical and lab services and community-level resource mobilization. For specialist care, the issue is how their activities are linked to other services. A rational referral system implies the need for specialists at secondary and tertiary levels; where resources permit, some specialization may be appropriate at the primary health care level.

A recent publication demonstrates that long-established disease-specific approaches to services delivery usually do not identify commonalities between programs, thus are unable to improve joint care. On the other hand, integration of programs (for example TB and NCDs) allows implementing common activities that recognize shared risk factors, comorbidities and implementing a common management approach, increasing the efficiency of interventions and optimizing resources and impact.

In additional, consideration also needs to be given to upstream NCD programme integration, as part of a wider system of coordination and inter-linkage of services at the policy and planning, human resources,

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financing and surveillance levels. When implementing these complementary approaches, a mix of political, technical and administrative will and action will be required in order to effectively manage change in the way services are delivered. It may require action at several levels, including sustained leadership from the top and multisectoral and multistakeholder involvement and commitment throughout. Tooling and re-tooling of service providers is accordingly ensured to enable them to deliver the right care and the right service. It is also useful to look for good ‘entry points’ for enhancing integration and to consider what incentives (e.g. career enhancements) there are for health workers and their managers to change their behaviour.

Rani et al. conducted a qualitative study examining the status of governance response to NCDs at national level in different countries. They found that NCD programs were treated with a stronger managerial and implementation approach, rather than a technical expertise/advisory focus. This results in multi-sectoral plans that provide unclear prioritization, targets and costs and that diminishes their potential effectiveness. They recommend strengthening the technical and analytical capacity, at the MOH level, alongside the program management and implementation focus, developing the NCD plans in close consultation with sector-wide health and non-health stakeholders. Multi-sectoral plans should be coordinated and strengthened through optimal decision-making powers and resource commitment, complemented by sustained and integrated monitoring of outputs and evaluation of impact and effectiveness.\(^8\)

Effective integration aims to result in better and more holistic patient care, prevention and treatment outcomes, ensuring enhanced health outcomes for patients. It avoids duplication of efforts, maximizes synergies, ensures comprehensive promotion and behavior change and addresses prevention and treatment of diseases with shared risk factors and common management frameworks in a simultaneous and integrated manner. Although it may provide some savings, integrating new activities into an existing system cannot be continued indefinitely without the system as a whole being better resourced. An approach that integrates the prevention and control of NCDs across programme areas and into service delivery strategies is, overall, cost effective and efficient but, in addition, it prioritizes NCDs in the agendas of universal health coverage and people-centered primary health care and supports the realization of universal access and social justice.

An integrative approach that demonstrates the significant health impact of combined care is always beneficial, independent of country context, but particularly when resources are limited and countries face a double burden of disease (communicable and non-communicable diseases).\(^9\) Integration of health care delivery can lead to increased community involvement and greater overall satisfaction with those services. Integration can lead to reduced differences in access and utilization of services between gender, geographical and socioeconomic groups, and reduction of financial risks (out-of-pocket costs) for patients, resulting in greater equity in health care and outcomes.

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2. Overarching principles: Setting the scene

National NCD responses should be driven by a focus on people, families and communities in line with a life-course approach and population-based health care delivery strategies.

- Patients, families and communities should be meaningfully engaged in every aspect of health and healthcare.
- National NCD responses should reflect best practices, emerging evidence and the perspectives of key stakeholders.
- Health care systems need to prioritize disease prevention and health promotion.
- NCDs should be widely incorporated in strategies for people-centered integrated health services and UHC, with the understanding that existing service delivery programs can be enhanced/improved/made more efficient by incorporating NCDs: underscoring the co-benefits of integrative approaches, particularly be addressing shared risk factors and co-morbidities.
- “An effective national response for the prevention and control of NCDs requires multistakeholder engagement, to include individuals, families and communities, intergovernmental organizations, religious institutions, civil society, academia, the media, policy-makers, voluntary associations and, where appropriate, traditional medicine practitioners, the private sector and industry. The active participation of civil society in efforts to address NCDs, particularly the participation of grass-roots organizations representing people living with NCDs and their carers, can empower society and improve accountability of public health policies, legislation and services, making them acceptable, responsive to needs and supportive in assisting individuals to reach the highest attainable standard of health and well-being. Member States can also promote change to improve social and physical environments and enable progress against NCDs including through constructive engagement with relevant private sector actors.”

Strong and sustained high-level political commitment to drive cross-sectoral integrated NCD-specific and sector-wide approaches.

- Ministry of health and sub-national health authorities need to build on process of revision and/or development of national cross-sector health policies and strategies that incorporate the prevention and control of NCDs and that ensure adequate prioritization, costing and appropriate targets.
- Ensuring full realization of the relevant commitments adopted in the 2011 and 2014 UN General Assembly High-Level Political Declarations.
- The sector-wide health plans should reflect NCDs in proportion to their public health importance and in line with in indivisible and integrated SDG-approach.

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• Policy-makers can provide leadership by making smarter investments for health, engaging relevant sectors for enhanced national multisectoral collaboration and coordination, enabling proper participation of communities, and ensuring institutional and financial mechanisms are fit for purpose. Also, by building institutional and individual capacity of health leaders (at the national, sub-national and facility level) to transform service delivery with a focus on developing quality interpersonal and inter-institutional relations.

• As integrated people-centred health care services reverse the focus from institutions and diseases to people, resource planning should evolve accordingly from vertical programs and rigid norms to “smart” capacity planning based on well-defined population needs and health pathways (flows) across levels of care, consistent with the model of care and (redefined) roles and missions of health care organizations. ¹¹

• Promoting whole-of-government and whole-of-society responses: Effective NCD prevention and control require multisectoral approaches at the government level including, as appropriate, a whole-of-government, whole-of-society and health-in-all policies approach across such sectors as health, agriculture, communication, customs/revenue, education, employment/labour, energy, environment, finance, food, foreign affairs, housing, industry, justice/security, legislature, social welfare, social and economic development, sports, trade, transport, urban planning and youth affairs (Appendix 5). Approaches to be considered to implement multisectoral action could include, inter alia:
  i. self-assessment of Ministry of Health,
  ii. assessment of other sectors required for multisectoral action,
  iii. analyses of areas which require multisectoral action,
  iv. development of engagement plans,
  v. use of a framework to foster common understanding between sectors,
  vi. strengthening of governance structures, political will and accountability mechanisms,
  vii. enhancement of community participation,
  viii. adoption of other good practices to foster intersectoral action and
  ix. monitoring and evaluation. ¹²

Implement responses for the prevention and control of NCDs based on human rights and equity-based approaches, and poverty-reduction strategies.

• Include strategies for the prevention and control of NCDs in national social/development plans
• Particular focus on vulnerable populations and patients with multiple chronic diseases (co-morbidities).
• These principles and approaches are relevant for all countries, whether with high, medium and low revenues, with mature or fragile health system

¹¹ WHO’s Draft Call for action for Integrated People Centred Health Services (IPCHS)
• WHO is in the process of finalizing the Innov8 Approach for Reviewing National Health Programmes to strengthen action on equity, gender, human rights and social determinants of health. The Innov8 Approach aims at ensuring that “no one is left behind” in health programmes.

Involvement/engagement/empowerment of civil society is essential in formulating and implementing policy decisions.

• Integration is grounded in an institutional culture of collaboration and engagement with the community, as a precursor to engagement with service users. It builds on encounters between the community, patients and their families with health service providers. This represents a major shift of focus, from institutions to people, recognizing the complexity and the unique value of their experiences and needs.
• Youth, family, communities and patients are informed about their rights or entitlements and can raise awareness and advocate for integrative approaches. Empowering and engaging people with information, skills and resources that they need is essential in order to make effective decisions about their own health, and be articulate and empowered users of quality health services.

3. Draft Preliminary Recommendations

3.1 Governance/Upstream/Vertical

**Recommendation 1**

All programme and health system funding, management and service delivery should support integrated people-centered health care and population-based health strategies.

**Policy options:**

• Integrated vertical and cross-cutting programmes and strategies should promote and prioritize a focus on people, families, and communities through a life-course approach, oriented towards the implementation of integrated people-centred primary health care and universal health coverage.
• Promotion and preventive approaches should be the foundation of a multisectoral NCD response, with clear investments in holistic care prioritizing health promotion and primary prevention strategies that support people’s health and wellbeing.
This will require effective promotion, adaptation and implementation of WHO’s Framework on integrated people-centred health services.\(^\text{13}\)

It calls for a comprehensive approach with a greater emphasis on prevention and effective management of diseases, coordination of care, and multidisciplinary teams. Engaging communities, patients, and families is an essential component of this approach.

Governments should channel vertical and cross-cutting resources into creating more equitable, accessible and sustainable health services that seek to better co-ordinate care around people’s needs and to secure improved health for people and populations.

This may require moving away from line budgeting and/or fee-for-service payment to mixed payment systems (e.g. partial capitation with some fee for service for priority services of high effectiveness and public health importance)

This supposes strong leadership and management capacity of local health authorities as it implies decentralization of decisions on resources allocation.

**Recommendation 2**

Policy makers require context-specific evidence, best practices and business cases for effective integration in order to ensure prioritization and integration of NCDs and other program areas in national health strategies.

Policy options:

- Ensure integration of NCDs and other program areas, in particular with HIV, TB, MCH, SRH, supported by evidenced-based, focused and shared joint-indicators.

- Build context/country-specific business cases for integration: burden of disease, health and economic impact, action vs inaction. This is critical, for health teams and hospitals, among other stakeholders, to understand the health needs of the population they serve and adapt supply of services, to implement population-based services, and to better manage patient’s individual needs.

- Build on and enhance body of evidence demonstrating effectiveness and impact of integrative approaches that have been experimented and implemented in various settings, with a particular focus on implementation research. Before implementing best practices, consider recognizing local specificities and regulating local adaptation to needs through priority public health interventions

- Develop, implement and disseminate concrete models for NCD management – considering promotion, prevention and treatment access - including NCD specific indicators

- Consider existing tools (i.e. WHO’s Innov8\(^\text{14}\), and PEN\(^\text{15}\))

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Recommendation 3

Governments require focused support from international development partners and intergovernmental organizations for effectively implementing the integration of the prevention and control of NCDs with other programme areas, in line with national priorities.

Policy options:
- International development partners, intergovernmental organizations and national, regional and international development plans (i.e. donors, development aid agencies, UNIATF, UNDAF, CCS, Development plans) should support for and provide follow-up of integrative NCD strategies aligned with country priorities.
- Technical assistance and guidelines from UN Agencies, including WHO, should promote and implement coordination, alignment and integration.
- National leadership should promote and ensure alignment of international development support with national priorities on integrative strategies.
- Civil society (i.e. policy-makers, health professionals, communities and patients) can ensure support from the international community.

Recommendation 4

Enhanced government commitment is required for building adequate and sustainable health workforce to manage and integrate NCDs.

Policy options:
- Promote the production, training and retention of health workers with a view to facilitating adequate deployment of a skilled health workforce within countries and regions, in accordance with the World Health Organization Global Code of Practice on the International Recruitment of Health Personnel.
- Integrate the prevention and control of NCDs in all phases of health workforce training, development and management, as well as in wider health sector strategies.
- Map local and national health workforce resources and requirements, including a comprehensive review of health professional training institutions, based on the health needs of

the communities and support/adjust pre-service and in-service training curricula and approaches, as appropriate to local context.

- Pre-service training
- Review and update health workforce curricula and methods
- Continuous training, updated protocols
- Competencies, skill sets, knowledge skills
- Performance measure, feedback and incentive for integration

- Strengthen the ability of national institutions to develop and implement more effective evidence-based health workforce policies and strategies, including appropriate regulation for the health workforce, adopting a person-centred health care delivery model and a diverse, sustainable skills mix geared to primary health care and supported by effective referral and links through all levels of care to the social services workforce.

**Recommendation 5**

Governments need to ensure the promotion, development and implementation of High-level Multisectoral Mechanism/Commission on NCDs with clear leadership from the health sector.

**Policy options:**

- Consider establishing, as appropriate to the respective national context, a national multisectoral mechanism, such as a high-level commission, agency or task force for engagement, policy coherence and mutual accountability of different spheres of policymaking that have a bearing on non-communicable diseases, in order to implement health-in-all-policies and whole-of-government and whole-of-society approaches, and to monitor and act on the determinants of non-communicable diseases, including social and environmental determinants.¹⁷

- Multisectoral coordination mechanisms need to be strengthened with optimal decision-making powers, resource commitment and monitoring of outputs, with a particular focus on strengthening governance and accountability.

- Multisectoral coordination mechanisms should demonstrate effective leadership in closing the gaps between policy-makers, academics and researchers, managers, providers and users, in order to identify and evaluate opportunities/bottlenecks, scale up and/or sustain and needed systemic changes (including in the regulatory frameworks) to generate and translate evidence for policy.

- Multisectoral coordination mechanisms require an appropriate and comprehensive stakeholder mapping, with a view to creating effective networks between health and other sectors and

establish a shared diagnosis of the situation and identify most relevant and feasible interventions, through a participatory and inclusive processes.

- They require the development of an implementation plan with clear goals, measurable objectives and defined roles and responsibilities, including for different stakeholders on how they work

### 3.2 Service delivery/Downstream/Horizontal

**Recommendation 6**

Governments need to ensure that quality NCD services are incorporated and integrated in primary health care and that quality and timely referral systems are functional.

**Policy options:**

- Promote, adapt and implement WHO’s *Package of Essential Noncommunicable (PEN) Disease Interventions for Primary Health Care in Low-Resource Settings*. 18
- The definition or revision of the benefit package (“what services should be made available and under what conditions”) is a foundational issue as it fosters a rights-based approach, enabling monitoring and accountability for effective availability of services and it drives organization and financing of services.
- Ensure that competent workforce with appropriate technical skill in specialty care is available to back up referral systems and screening programs.

**Recommendation 7**

Integration of the prevention and control of NCD at service delivery level should be comprehensive/horizontal, but may require starting from the successes of integrating with vertical programs (such as HIV, TB, MCH, SRH).

**Policy options:**

- Promote the clear value of providing a log frame as a tool for mapping entry points for integration across program areas and with a focus on primary health care and universal health coverage, with a view to compile and disseminate an “integration roadmap”.
- Promote, adapt and implement lessons learned and scale up best practices from countries which have successfully added NCD components to existing programme areas

**Recommendation 8**

Effective integration of NCDs with other programme areas requires the optimal and efficient use of

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existing or available human resources, in particular through “task-shifting or task sharing”, complemented by adequate resources, supervision and oversight and incentives.

**Policy options:**

- This will require “the best use of limited resources and ensuring that they are deployed strategically, recognizing the potential of multidisciplinary team-based approach at the primary care level for integrated people-centered health care, exploiting the potential contribution of different typologies of health workers, operating in closer collaboration and according to more rationale scope of practice.”\(^{19}\), in order to effectively match the supply and skills of health workers to disease burden and population needs.
- A progressive shift in the demand for patient-centred care, community-based health services, and personalized long-term care demand for a substantial growth of health workforce with integrated skills.
- Promote and implement task-shifting/sharing which also covers volunteers, when appropriate.
- Realizing this agenda requires the following: appropriate regulation for health workforce education on NCDs; a more sustainable and responsive skills mix for an integrated response, harnessing opportunities from the education and deployment of community-based and mid-level health workers; improved deployment strategies and working conditions; incentive systems; enhanced social accountability; inter-professional collaboration; and continuous professional development opportunities; and career pathways tailored to gender-specific needs in order to enhance both capacity and motivation for improved performance\(^ {20}\).
- Community health workers (CHWs) should be clearly recognized by integrating them into national health workforce plans for NCDs, adequately supported, resourced and incentivized.

**Recommendation 9**

Governments should invest in research and implementation of innovative technologies, including e-Health and m-Health, to support integration, scale-up and outreach of NCD strategies and programs

**Policy options:**

- Recent advances in information technologies (shared electronic records, m-health, telemedicine, less invasive procedures) provide support for successful implementation.
- Promote, adapt and implement lessons learned and scale up best practices from countries which have successfully prioritized these investments.

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\(^{19}\)Draft Call for action for Integrated People Centred Health Services (IPCHS)

4. Tables

4.1 Ten key principles for successful health systems integration

The table below, based on Ten Key Principles for Successful Health Systems Integration, by Suter et al., identifies ten universal principles of successfully integrated healthcare systems which may be used by decision-makers to assist with integration efforts. Recognizing there is no one-size-fits-all model or process for successful integration these principles define key areas for restructuring and allow organizational flexibility and adaptation to local context.

<table>
<thead>
<tr>
<th>Principle</th>
<th>Implementation example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comprehensive services across the continuum of care</td>
<td>Integrated health systems are responsible for health promotion and management from primary through to tertiary care, in close cooperation with community-based organizations and health systems. These cover preventive, curative and rehabilitative delivery of services.</td>
</tr>
<tr>
<td>2. Patient, family and community focused</td>
<td>Service planning and information management are driven by needs assessments and processes designed to improve patient and family satisfaction and outcomes both for individual patients and for populations. Integration encompasses the rights of patients. Integrated health systems should be easy for patients to navigate and should prioritize patient and community engagement, participation and empowerment.</td>
</tr>
<tr>
<td>3. Geographic coverage and equity</td>
<td>The system takes responsibility for ensuring affordable access to and appropriate utilization of needed quality services for clearly defined populations and geographic areas</td>
</tr>
<tr>
<td>4. Deliver care based on evidence-informed guidelines</td>
<td>Best practice guidelines, health promotion and clinical care pathways and decision-making tools standardize and enhance health promotion and quality of care.</td>
</tr>
<tr>
<td>5. Performance monitoring</td>
<td>Monitoring systems that consist of protocols and procedures, measure care processes and outcomes at different levels, and are linked to reward systems to promote the delivery of cost-effective quality care.</td>
</tr>
<tr>
<td>6. Information systems</td>
<td>Computerized information systems allow effective tracking of</td>
</tr>
</tbody>
</table>

| **7. Organizational culture and leadership** | Committed leadership brings individuals and inter-professional and multidisciplinary teams together, promotes the vision and mission of integration, ensures opportunities, resources, incentives and rewards for staff learning, performance and ownership of the process. |
| **8. Health professional integration and care delivery through inter-professional and multidisciplinary teams** | Physicians, nurses and nurse practitioners, including those from the private sector, are effectively integrated at all levels of the system and play leadership roles in health system design, implementation and operation; well-functioning inter-professional and multidisciplinary teams result in efficient care and enhanced satisfaction and health outcomes. Integration is embedded in training curriculum of different cadres of health care professionals. |
| **9. Governance structure** | Governance structures promote integration and are diversified, ensuring representation from a variety of stakeholders involved in the delivery of healthcare, including the health workforce and the community. The organizational structure is independent of, but accountable to, government and the health organizations. Strategic alliances with external stakeholders, government and the public are essential, as are incentives that influence providers’ attentiveness to costs and quality of services. The complexity of systems requires effective and inclusive coordination for accountability and decision-making, with convergence at policy, planning and budgeting levels so that ‘integration’ is embedded in the entire health delivery system. |
| **10. Financial management** | Financing mechanisms allow pooling of funds across needed services, for example, through global capitation, which pays for all insured health and some social services required by the enrolled population. Finance mechanisms to support health system strengthening are equally relevant for integration. (Outsourcing the services of transport/courier companies to accommodate the distribution/delivery of all program commodities rather than having different mechanisms per program) |
4.2 Potential efficiency gains from integration

The below table on potential efficiency gains from integration is extracted from Sweeney et al.\textsuperscript{22} to describe the potential effect of integration at each level of a health system. It recognizes that integration can contribute to efficiency gains beyond the improvement in allocative efficiency at the service level.

| 1. | Integration of governance (such as through coordination of strategic and operation planning and performance monitoring) may improve technical efficiency by sharing scarce resources (including human resources, such as clinicians, skilled planners and managers.) Joint or coordinated planning and management of scarce resources, monitoring and evaluation, and reporting may also improve allocative efficiency. |
| 2. | For patients, communities and families integration may lead to better quality care, improved health behaviors and action for early diagnosis, less fragmented services, better access, improved health promotion, higher levels of continuity of care, better referral systems, and greater satisfaction with care and improved outcomes. Integration also may reduce patient/community-level costs resulting from improved self-management, fewer visits to facilities, greater proximity of services and reduced delays in seeking consultation to access diagnosis and treatment. |
| 3. | Integration of financing may improve technical efficiency by merging and reducing the costs of separate financing and reporting systems. Co-ordinated financing may also impact allocative efficiency by reducing perverse incentives that may be created by competing programmes. |
| 4. | Health management systems integration can facilitate improvements in technical efficiency through reductions in management systems costs, such as through joint procurement, sharing of middle managers, joint training and supervision, sharing information, education and communication materials, and joint management information systems. |
| 5. | Facility integration can contribute to improved outcome and reductions in facility costs resulting from joint utilization of space, major equipment, and other fixed factors of production. |

\textsuperscript{22} Based on Sweeney S, Obure CD, Maier CB, Greener R, Dehne K, Vassall A. Costs and efficiency of integrating HIV/AIDS services with other health services: a systematic review of evidence and experience. Sex Transm Infect. 2012; 88:86.
4.3 Potential challenges for integration of NCDs and possible actions to overcome them

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Context</th>
<th>Actions</th>
</tr>
</thead>
</table>
| 1. Lack of political will for prioritizing and implementing integration | • Lack of strong leadership (Ministries of Health and/or subnational level)  
• Lack of sustainability; rapid turnover of leaders; service delivery systems without engagement of sustainable clinical leaders and institutions  
• Varying priorities of leaders | • National and/or subnational centralized multi-sectoral coordination mechanism/agency  
• Develop context-specific business case documenting the evidence of costs and benefits, and rationale for integrating NCDs into identified services  
• Sustainable M&E and accountability frameworks;  
• Country ownership of health and development assistance  
• A clear understanding that the attainment of the SDGs requires integration; thus, national strategic plans, anchored on reaching the SDGs, should consider integrated approaches. |
| 2. Difficulty in defining local evidence-based approaches for effective integration and developing national proposals on integration | • Lack of guidance and best practices for informing integrated services  
• Lack of context-specific evidence and data  
• Evidence stays in piloting stage, without guidance or evidence on scale up/mainstreaming  
• Lack of approaches that fit local context and infrastructure | • Need to define and map priorities based on local context, such as country and community needs, geographical situation, available resources, and existing organization and management infrastructures.  
• Develop indicators to assist in monitoring the whole system and its constituent parts at local level, to measure quality of service, equity of access and output against the cost  
• Log frame  
• Decentralization of health service delivery  
• Clarity on definition of integration and how integration could be achieved by all stakeholders involved  
• Clearly defined objectives, targets, plans and outcome monitors for the approach |
| 3. Lack of health system and stakeholder commitment, coordination and consensus | • Diversity of views about the issues/priorities across different sectors, e.g. different concerns from public health professionals, politicians, economists and civil society, leading to fragmented | • National and/or subnational multi-sectoral coordination mechanism/agency  
• Coordinated planning and well-resourced communication strategy to achieve a paradigm shift that promotes |
4. Health systems prioritization of single-disease treatment

<table>
<thead>
<tr>
<th>Approaches to their solutions</th>
<th>A holistic view of the health by different sectors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of cross-sectoral communication within governments</td>
<td>Advocacy for integration initiated with and among relevant ministries at both national and district levels,</td>
</tr>
<tr>
<td>Poor understanding of, and agreement on, terminology and activities regarding integration across programme areas</td>
<td>Community mobilization</td>
</tr>
<tr>
<td>Sectors’ desire to defend “territorial gains and rights”, unaware of interlinkages between their work and other sectors</td>
<td>Log frame</td>
</tr>
<tr>
<td>Difficulty in identifying opportunities and co-benefits for integration at different stakeholder levels and ways in which activities can reinforce one another.</td>
<td>A district development committee to be set up with the task of preparing an overall district development plan. This plan will include clear roles to be taken by the various levels and elements in implementing the plan, with a clear definition of accountability and responsibility of all parties.</td>
</tr>
<tr>
<td>Competitive mindset between health system levels, programmes and institutions</td>
<td>Advocacy for attitude change to bring about cooperation instead of competition regardless of budgets or funds available.</td>
</tr>
<tr>
<td>Barriers to inter-professional collaboration</td>
<td>Partnership-building to allow different levels to share vision and goals, and to be prepared to work together to achieve these goals using common resources and technologies</td>
</tr>
<tr>
<td>Perception that less funded programs have less priority.</td>
<td>Programmes and systems not under a coordinated command at national, district, municipal or community level.</td>
</tr>
<tr>
<td>Perpetuation of separate planning, reporting, monitoring, evaluation and accountability mechanisms focused on specific programme areas, in many cases to meet donor demands and in context of projects rather than institutionalizing the processes and the systems.</td>
<td>National and/or subnational multisectoral coordination mechanism/agency</td>
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<tr>
<td>Siloed programme management including funding: Resources/funds are generated according to specific program activities; and similarly, funds are made available in response to specific program activities.</td>
<td>NCDs well integrated into national health and development plans</td>
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<tr>
<td>Acute care mindset vs promotion and prevention</td>
<td>Reframing national development plans to incorporate SDGs, including UHC and a rights-based approach to population health</td>
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<tr>
<td>Sustained funding gaps for many program areas, e.g. NCDs and SRH are underfunded and may be competing for funds</td>
<td>A district development committee to be set up with the task of preparing an overall district development plan. This plan will include clear roles to be taken by the various levels and elements in implementing the plan, with a clear definition of accountability and responsibility of all parties.</td>
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<tr>
<td>Focus is on what works well for the</td>
<td>Advocacy for attitude change to bring about cooperation instead of competition.</td>
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<td></td>
<td>Engagement with health sector in developing the integration plans, and communicate a clear vision that has benefits for the service, for patients (win-win scenarios)</td>
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<td></td>
<td>Develop promotion and prevention strategies that overarch</td>
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services, rather than being person/client-centred and focusing on what works best for people/patients.

- Integrating existing structures or systems and changes in roles can give rise to competition rather than integration

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<tr>
<th>5. Overloaded health workforce and unclear development and support for integration</th>
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<tr>
<td>In the context of a shortage of health workforce, requirements for multidimensional skills and expertise may overburden clinicians and community health workers,</td>
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<tr>
<td>- Multiple responsibilities may be added to community staff without being cognizant of their current workload and without adequate training including in prioritization or problem solving, leading to diluted messages and services, poor quality of interventions, poor patient satisfaction and potential staff burnout and poor retention.</td>
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<td>- Families may also be at risk of receiving too much information at one time, not knowing how to prioritize or digest all of the information received.</td>
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<td>- Inadequate advocacy and sensitization on the benefits of integration</td>
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<tr>
<td>- Limited availability of health workforce data</td>
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<tr>
<td>- Difficulties in deploying health workers to rural, remote and underserved areas</td>
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<tr>
<td>Task shifting: moving tasks away from more specialized health professionals to less specialized health workers</td>
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<tr>
<td>- Comprehensive mapping of local health workforce</td>
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<tr>
<td>- Comprehensive professional training: an updated curriculum with analysis of functions and task definitions in an integrated health system.</td>
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<tr>
<td>- Training and continuous development of health professions should reflect a holistic approach to health care. Training should allow staff to have the skills and knowledge to appreciate the role of and work with and support colleagues across disciplines.</td>
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<td>- Clear job descriptions, revised periodically, that define staff roles and responsibilities for integrated programming.</td>
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<td>- Simple guidelines, standardized protocols; consistent training of both front-line and specialized health care workers</td>
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<tr>
<td>- Incentivizing organic and community health workers</td>
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<td>- Employ reward or merit system for successful integrated practices and initiatives</td>
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<td>- Strong supervision, coaching, accountability and incentive mechanisms</td>
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<th>6. Poor community engagement and empowerment</th>
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<tr>
<td>Lack of experience in or support of community-based action or task shifting/sharing by many health professionals.</td>
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<td>- Lack of understanding of knowledge and resources found in community health workers and support systems.</td>
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<td>- Centralized health services and, in some cases, little tradition of active</td>
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<td>- Prioritization of health education and health literacy programs and strategies, defined for specific audience groups.</td>
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<tr>
<td>- Country owned solutions with demonstrated effects which are then ready to take to scale.</td>
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<tr>
<td>- Incorporation of integrative principles in professional training/curriculum</td>
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<tr>
<td>- Decentralization of health services, with enhanced collaboration at local levels</td>
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</tbody>
</table>
| Partnership between government sector and communities. Multi-sector or community participation may be hampered by bureaucratic structures, and community action for health becomes a bottleneck for integration.  
  - Limited health literacy in some communities | Civil society empowerment and participation, particularly through multistakeholder engagement and coordination mechanisms and/or incentives  
Create an environment where communities are empowered to engage on specific tasks that they can sustain across time (e.g. assigning community health workers as treatment partners for diabetic patients undergoing TB treatment) |
|---|---|
| **7. Health system research** | Enhance priority of organizational studies in support of integration, through engagement of academia and local and international technical support  
Strengthen political commitment, financial support, multidisciplinary input and a long-term commitment to implementation studies,  
Develop policy frameworks for integrating top-down and bottom-up approaches to organizational change,  
Lack of implementation research related to integration of services and the process of organizational change and decision-making processes to support integration  
Shortage of appropriate research methods and skills.  
Over-reliance on traditional public health institutions.  
Lack of evidence on how to scale-up or roll out pilot projects throughout the whole service/system. | |
| **8. Weak and siloed monitoring and evaluation** | Integration of governance, through joint coordinated planning and management, monitoring and evaluation and reporting  
Adapt/create a set of minimal key joint indicators to monitor and evaluate progress  
Develop a global or regional compendium of indicators related to integration that countries can adopt for their own monitoring  
Limited indicators to measure integration  
Current M&E tools address specific programs, not integration outcomes or impact | |